Multiple Drug Therapy Regimen Review (Polypharmacy)

Prepared for << Client>> by ACS Rx Delivery Services

☒ **Initial Study** ☐ **Follow-up/Restudy**

EXECUTIVE SUMMARY

Purpose: To increase prescriber awareness of patients on polypharmacy regimens and to encourage review of the identified therapy. This may result in discontinuation of drug therapy that is no longer necessary.

Why Issue was Selected: Studies have shown that when a drug therapy regimen consists of 5 or more drugs, significant risk of drug related problems results.[1,2] Patients who receive multiple drugs are at an increased risk for drug-drug or drug-disease interactions, duplicate therapy or unnecessary therapy, medication non-adherence, and hospitalization.

Program Specific Information: During our recent analysis of your program in (month/year), the following polypharmacy exceptions were identified:

Identified Polypharmacy Regimens	**# Patients**
20 or More Medications* with:	
Opiates from 3 or more Prescribers and Pharmacies	
3 or more Prescribers and Pharmacies	
3 or More Prescribers	
2 Prescribers	
1 Prescriber	
Total	
15-19 Medications* with:	
Opiates from 3 or more Prescribers and Pharmacies	
3 or More Prescribers and Pharmacies	
3 or More Prescribers	
2 Prescribers	
1 Prescriber	
Total	
10-14 Medications* with:	
Opiates from 3 or more Prescribers and Pharmacies	
3 or More Prescribers and Pharmacies	
3 or More Prescribers	
2 Prescribers	
1 Prescriber	
Total	
≥ 10 Medications* with a history of cancer, HIV or chronic renal insufficiency/failure	
Total Patients	

* Antibiotics are not counted.

Setting & Population: All patients 18 years of age and older who have had 10 or more medications (excluding antibiotics) filled within the most recent 30 days of claims activity.

Type of Intervention: Cover letter and individual patient profiles

Main Outcome Measures: Re-measure performance indicators

Anticipated Results: Decrease in the number of medications taken per patient.

PURPOSE OF INTERVENTION

The purpose of this intervention is to increase prescriber awareness of patients on polypharmacy regimens and to encourage review of the identified therapy. Review of therapy may result in discontinuation of drugs that are no longer necessary.

WHY HAS THIS CLINICAL ISSUE BEEN SELECTED FOR REVIEW?

Studies have shown that when a drug therapy regimen consists of 5 or more drugs, significant risk of drug related problems result.[1,2] Patients who receive multiple drugs are at an increased risk of drug-drug or drug-disease interactions, duplicate therapy or unnecessary therapy, medication non-adherence, and hospitalization. The cost of drug related morbidity and mortality resulting from drug related problems are estimated to be $177 billion annually.[3] A reduction in the number of medications taken per patient can result when multiple drug therapy regimens are brought to the attention of the prescriber.[4,5]

SETTING AND POPULATION

Date Range of Analysis: To be determined for each client.
Business Units Reviewed: To be determined for each client.
Estimated Date of Mailing: To be determined for each client.

PERFORMANCE INDICATORS

Indicator #1: Polypharmacy

Why has this indicator been selected? Encouraging prescriber review of patients on a polypharmacy regimen may result in discontinuation of therapy considered no longer necessary.

How will the patients be selected?

Candidates (denominator): All patients 18 years of age and older with pharmacy claims activity within the most recent 30 days. Antibiotics are excluded.

Exception criteria (numerator): Patients who have had 10 or more medications filled during the most recent 30-day time frame.

INTERVENTION MATERIAL

This intervention consists of a physician mailing containing a cover letter and patient profiles with a polypharmacy regimen.

OUTCOMES MEASUREMENT

The outcomes measurement of this intervention group will take place when six months of post-intervention claims data have been received and validated. The outcomes assessment will include an evaluation of the targeted intervention group compared to a control group. The groups will be evaluated for changes in the number of medications taken per patient.

ANTICIPATED RESULTS

Providing prescribers with information on their patient's polypharmacy regimen encourages review of the identified drug therapy with potential discontinuation of therapy considered no longer necessary.

REFERENCES

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Template: Polypharmacy Analysis

Date

<<Name>>
<<Address>>
<<Address>>

RE: Multiple Drug Therapy Regimen Review (Polypharmacy)

Dear Dr. <<NAME>>:

The goal of this quality management program is to assist you in caring for your patients using multiple drug therapies. Patients who receive multiple medications are at an increased risk of drug-drug or drug-disease interactions, duplicate or unnecessary therapy, non-adherence, and hospitalization. One study documented that negative outcomes related to drug therapy caused 33% of emergency department visits and 73% of the negative outcomes were considered preventable.[1] Other studies have shown that when a patient has multiple providers they tend to take more medications and have greater risk for adverse drug events.[2,3] Improvements in communication between providers and better coordination of care may lessen potential problems. A reduction in the number of medications taken per patient can result when multiple drug therapy regimens are brought to the attention of the prescriber(s).[4,5]

<<CLIENT>> Specific Data

Polypharmacy Indicator Summary	Number of Patients with Opportunities*
• Receipt of 10 or more medications (excluding antibiotics) within a 30-day time frame	X

*Based on data through <<time period>>.

The enclosed patient profile(s) reflect the above issue and are provided as a chart reminder for when your patient(s) return for their next appointments. Multi-drug therapy regimens may be necessary to treat certain medical conditions. However, all multi-drug therapy regimens merit periodic review to minimize potential risk or development of drug related problems. Communication with other providers about potential concerns should be undertaken when necessary.

We acknowledge that there may be clinical variables influencing an individual patient's management that are not apparent in claims data or that a patient may have been inadvertently identified as being under your care. However, we believe the issues identified will assist you in caring for your patient(s). We thank you for reviewing this information and caring for **<<Client>>** Medicaid's patients and welcome the opportunity to discuss any comments or concerns you may have about our quality management program. Please feel free to call our office at _____ with questions or concerns.

Sincerely,

Jane Doe, M.D.
Medical Director

Jack Smith, M.D.
Chairman, Medicaid Drug Use Review Board

OVER

References:

1. Baena MI, Faus MJ, Fajardo PC, et al. Medicine-related problems resulting in emergency department visits. Eur J Clin Pharmacol. 2006; 62:387-93.
2. Green JL, Hawley JN, Rask KJ. Is the number of prescribing physicians an independent risk factor for adverse drug events in an elderly outpatient population? Am J Geriatr Pharmacother. 2007; 5:31-9.
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Treatment of Chronic Noncancer Pain (CNCP) with Opiates

Prepared for << Client>> by ACS Rx Delivery Services

☒ **Initial Study** ☐ **Follow-up/Restudy**

EXECUTIVE SUMMARY

Purpose: This intervention is designed to improve the appropriate and effective management of chronic noncancer pain (CNCP) with opiate analgesics.

Why Issue was Selected: Pain is one of the leading reasons patients consult physicians. The annual cost of chronic pain in the United States is estimated to be $100 billion.[1,2] The American Pain Society and the American Academy of Pain Medicine consider opiates an important component in the pharmacological treatment of chronic pain.[3,4]

Program Specific Information: In our recent analysis (MM/YY) of your program, we found these exceptions to clinical criteria that are relevant to this intervention:

Performance Indicators	Exceptions
• Increased risk of adverse drug event: excessive dose of tramadol or opiate analgesics containing acetaminophen or ibuprofen	*x,xxx*
• Increased risk of adverse event: tramadol use with renal or hepatic disease	*x,xxx*
• Increased risk of adverse event: pediatric use of tramadol	*x,xxx*
• Increased risk of adverse drug event: meperidine	*x,xxx*
• Underutilization of long-acting opiates	*x,xxx*
• Coordination of care: use of multiple opiates from multiple prescribers	*x,xxx*

Setting & Population:
- All patients with current drug claims for an opiate analgesic and opiate claims activity within the past six months
- Exclusions: All patients with malignant neoplasms (ICD-9 140.xx-208.xx) as designated in the performance indicators

Type of Intervention: Cover letter, sample patient-physician contract, and modified patient profiles

Main Outcome Measures: The performance indicators will be remeasured 6 months post-intervention.

Anticipated Results:
- Decreased adverse drug events associated with opiate therapy
- Increased utilization of long-acting opiates leading to improved pain control
- Improved coordination of care

PURPOSE OF INTERVENTION

This intervention is designed to promote safe, cost-effective use of opiate analgesics in the management of chronic noncancer pain (CNCP). The intervention materials encourage providers to:

- Assess opiate medication regimens and discontinue ineffective or potentially unsafe opiate analgesics;
- Consider initiating a long-acting opiate medication to achieve better pain control in patients using short-acting opiate medications frequently;
- Review overall opiate utilization to identify patients receiving opiate analgesics from multiple providers and improve coordination of care.

WHY HAS THIS CLINICAL ISSUE BEEN SELECTED FOR REVIEW?

Over 76.5 million Americans suffer from chronic pain. Pain is one of the leading reasons patients consult physicians, and it is the second leading cause of medically related work absenteeism, resulting in over 50 million lost workdays each year. The annual cost of chronic pain in the United States is estimated to be $100 billion.[1,2] Chronic noncancer pain (CNCP) is commonly defined as pain existing beyond an expected time frame for tissue healing (typically 3-6 months).[3] The American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) consider opiates an important component in the pharmacological treatment of chronic pain. They published a consensus statement and treatment guidelines to help support a practice environment where opiates are used appropriately while minimizing needless suffering from pain.[3,4]

Barriers to effective management may originate from both the physician and patient. Physicians may have inadequate training in pain management or may have concerns of legal sanctions associated with opiate use. Physicians and patients may also share misconceptions regarding addiction, tolerance, dependence, safety and efficacy of opiate analgesics. The actual rate of addiction related to opiate use when given for pain relief is low. Tolerance to analgesic effects seldom develops after days or weeks of opiate therapy and is usually indicative of disease progression and not because of a loss of analgesic effects from the opiate. In addition, chronic use of opiates is generally not associated with significant cognitive impairment.[3-9]

Many opiate analgesics are safe and effective when used properly; however, there are risks associated with inappropriate use. Inappropriate use may include prescribing excessive doses, continuing therapy indefinitely without justification, and using opiates when a safer, more appropriate treatment choice is available. The adverse drug events that result from inappropriate use include respiratory depression, constipation, nausea, vomiting, addiction, physical dependence, and tolerance. Combination opiates have maximum daily doses based on the acetaminophen or ibuprofen content and optimal pain relief may be difficult to achieve with these agents due to the dosing limitations. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained opiate analgesic use and are not synonymous with addiction. Criteria that should be reviewed before initiating opiate therapy are listed in Table 1.

Table 1: Considerations Before Initiating Opiate Therapy in CNCP [3-6, 8-10]

❑ Specific therapies for a particular disease state and other types of analgesics should be given a full trial before initiating an opiate pain management program.
❑ A history of substance abuse should be viewed as a *relative* contraindication and may be more appropriately managed by a pain or addiction specialist.
❑ Patients should provide informed consent and complete a pain contract before initiation of long-term opiate therapy. The patient should also be educated on the safe and effective use of opiates.
❑ Medications should be administered on an around-the-clock basis.
❑ Emphasis should be given on improved analgesia by gains in physical and social function.
❑ A single practitioner should take primary responsibility for opiate therapy with regular assessment of treatment efficacy but a multidisciplinary approach to monitoring use may be helpful.

SETTING AND POPULATION

Date Range of Analysis: To be determined for each client.
Business Units Reviewed: To be determined for each client.
Estimated Date of Mailing: To be determined for each client.

PERFORMANCE INDICATORS

Indicator #1: Increased Risk of Adverse Drug Event: Excessive Dose of Tramadol or Opiate Analgesics containing Acetaminophen or Ibuprofen

Why has this indicator been selected?

By exceeding the recommended daily dosages, patients may be placed at an increased risk of experiencing an adverse event:

- Acetaminophen – hepatic impairment
- Ibuprofen – gastrointestinal bleed or renal impairment
- Tramadol – headaches, dizziness, seizures

How will the patients be selected?

Candidates (denominator): Patients receiving tramadol or opiate analgesics containing acetaminophen or ibuprofen in the last 60 days

Exception criteria (numerator): Candidates receiving greater than the recommended daily doses of tramadol or acetaminophen/ibuprofen (as part of a combination opiate product):

Tramadol Immediate-Release (IR), Orally Disintegrating Tablets (ODT):

- Candidates < 75 years of age receiving quantities > 400mg/day
- Candidates > 75 years of age receiving quantities > 300mg/day

Tramadol Extended-Release (ER): an average dose > 300mg/day

Acetaminophen:

- Quantities of an acetaminophen-containing opiate analgesic = > 4000mg acetaminophen/day

Ibuprofen:

- Quantities of an ibuprofen-containing opiate analgesic = > 3200mg ibuprofen/day

Indicator #2: Increased Risk of Adverse Drug Event: Tramadol Use with Renal or Hepatic Disease

Why has this indicator been selected?

Patients with renal disease or cirrhosis are at increased risk of adverse events if tramadol IR/ODT is not prescribed at recommended dosages. Tramadol ER should not be used in patients with a creatinine clearance less than 30 ml/min or in those who have severe hepatic disease (Child-Pugh Class C).

How will the patients be selected?

Candidates (denominator): Patients with a history of severe renal impairment, dialysis, or hepatic disease in the last 2 years who received tramadol in the last 60 days

Exception criteria (numerator): Tramadol IR/ODT:

- Renal disease or dialysis: candidates receiving quantities that could provide a daily dose exceeding 200mg

Tramadol IR/ODT:

- Cirrhosis: candidates receiving quantities that could provide a daily dose exceeding 100mg

Tramadol ER:

- Renal disease, dialysis or hepatic disease: candidates who have received tramadol ER in the last 60 days

Indicator #3: Increased Risk of Adverse Drug Event: Pediatric Use of Tramadol

Why has this indicator been selected?	The use of tramadol and tramadol ER has not been studied in patients less than 16 years of age and 18 years of age, respectively. Therefore, the use of tramadol is not recommended in these age populations.
How will the patients be selected?	
Candidates (denominator):	All patients who have received tramadol in the last 60 days
Exception criteria (numerator):	• Candidates less than 16 years of age receiving tramadol IR/ODT • Candidates less than 18 years of age receiving tramadol ER

Indicator #4: Increased Risk of Adverse Drug Event: Meperidine Use

Why has this indicator been selected?	Meperidine is not recommended in the treatment of CNCP. It has a neurotoxic metabolite, normeperidine, which accumulates with repeated dosing and can produce anxiety, tremors, myoclonus, and seizures. Meperidine should be avoided in patients with renal insufficiency. Finally, meperidine has a short duration of action and relatively large doses are required for the relief of moderate to severe pain. [11,12]
How will the patients be selected?	
Candidates (denominator):	All patients receiving oral meperidine in the last 60 days
Exception Criteria (numerator):	Candidates with a history of chronic renal insufficiency in the last 2 years or candidates receiving 3 or more prescriptions and 90 or more tablets of oral meperidine in the last 60 days

Indicator #5: Underutilization of Long-Acting Opiates

Why has this indicator been selected?	Excessive use of short-acting opiate analgesics may indicate inadequate pain relief. Although short-acting opiate analgesics are easier to titrate to pain relief, they require frequent dosing. In addition, chronic use of short-acting opiate analgesics has been shown to increase the potential for abuse; therefore, they are best reserved for breakthrough pain. Long-acting opiates can provide sustained pain relief with less frequent dosing.
How will the patients be selected?	
Candidates (denominator):	Patients receiving 8 or more short-acting opiate analgesic prescriptions within the last 150 days (excluding patients with a history of malignancies, migraine headaches or sickle cell disease)

Exception Criteria (numerator):	Candidates not receiving a long-acting opiate analgesic in the last 60 days

Indicator #6: Coordination of Care: Use of Multiple Opiates from Multiple Prescribers

Why has this indicator been selected?	In patients with CNCP, obtaining opiate analgesics from more than one physician may suggest the possibility of inadequate pain relief and pain management. To monitor and optimize the patient's opiate usage, opiates should be prescribed by only one physician or one chronic pain treatment team whenever possible. Treatment from one physician encourages continuity of care and can provide improved pain management.
How will the patients be selected?	
Candidates (denominator):	Patients receiving opiate analgesics in the last 60 days (excluding patients with a history of malignancies)
Exception Criteria (numerator):	Candidates that received 8 or more opiate analgesic prescriptions in the last 6 months from 4 or more physicians

INTERVENTION MATERIAL

The intervention will consist of a cover letter, modified patient profiles, and a sample patient-physician opiate contract.

OUTCOMES MEASUREMENT

The outcomes associated with this intervention will be measured when six months of post-intervention data are available, and will include evaluation of the targeted intervention group.

ANTICIPATED RESULTS

Physician reassessment of opiate analgesic regimens as a result of this mailing may provide improved quality of care and decrease drug therapy expenditures through discontinuation of inappropriate drug therapy, reduction in adverse drug events, increased utilization of long-acting opiate agents, and improved coordination of care.

REFERENCES

1. National Center for Health Statistics. Health, United States, 2006, with chartbook on trends in the health of Americans. Hyattsville, MD: 2006. Available at **http://www.cdc.gov/nchs/data/hus/hus06.pdf.** (accessed 10/20/10)
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3. Chou R, Fanciullo G, Fine P, et al. Opioid treatment guidelines: clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. J Pain 2009;10(2):113-130.
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5. Marcus DA. Treatment of nonmalignant chronic pain. Am Fam Physician 2000;61:1331-8.
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12. American Pain Society. Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain. 4th Edition (1999).

Template Name: Pain Management

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<Date>

<<Name>>
<<Address>>
<<Address>>

RE: Caring for Your Patients with Chronic Noncancer Pain (CNCP)

Dear Dr. <<NAME>>:

The goal of this quality management program is to assist you in caring for your patients with Chronic Noncancer Pain (CNCP). This program is based on guidelines provided by the American Pain Society and the American Academy of Pain Medicine, and is designed to assist you in maximizing patient outcomes and promoting patient safety.[1] Pharmacotherapy is often used to manage chronic pain and opiate analgesics are an important option. The safe and effective use of opiates is the focus of this intervention and for that reason; a sample opiate contract and a summary of pain management goals have been included in this letter.

Claims data indicates that in the <<CLIENT>> population, there were <<X,XXX>> prescriptions for opiate (narcotic) analgesics in the past year at a total cost of <<$XXXXX>>.

<<CLIENT>> Specific Data

CNCP Medication Management Indicator Summary	Number of Patients with Opportunities*
• Decrease the risk of adverse drug events associated with acetaminophen- or ibuprofen-containing opiates or tramadol	X
• Decrease the risk of adverse drug events associated with meperidine	X
• Maximize the use of long-acting opiate analgesics	X
• Identify potential coordination of care issues: patients using multiple opiates from multiple prescribers	X

*Based on data thru <<time period>>.

The enclosed patient profile(s) reflect one or more of the above issues and are provided as a chart reminder for when your patient(s) return for their next appointments.

We acknowledge that there may be clinical variables influencing an individual patient's management that are not apparent in claims data or that a patient may have been inadvertently identified as being under your care. However, we believe the issues identified will assist you in caring for your patient(s). We thank you for reviewing this information and caring for **<<Client>>** Medicaid's patients and welcome the opportunity to discuss any comments or concerns you may have about our quality management program. Please feel free to call our office at _____ with questions or concerns.

Sincerely,

Jane Doe, M.D.
Medical Director

Jack Smith, M.D.
Chairman, Medicaid Drug Use Review Board

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CNCP Medication Management Indicator Summary

- **Decrease the risk of adverse drug events associated with acetaminophen- or ibuprofen-containing opiates or tramadol**
  - Exceeding the recommended daily dosages may increase a patient's risk of experiencing an adverse event: acetaminophen – hepatic impairment; ibuprofen – gastrointestinal bleed or renal impairment; tramadol – headaches, dizziness, seizures.
  - Tramadol immediate-release doses need to be reduced in patients with renal impairment or cirrhosis, extended-release formulations are not recommended in patients with renal or hepatic disease.
  - Tramadol is not recommended for use in pediatric patients
- **Decrease the risk of adverse drug events associated with meperidine**
  - Meperidine is not recommended in the treatment of CNCP. It has a short duration of action and relatively large doses are required for relief of moderate to severe pain. Meperidine should be avoided in patients with renal insufficiency. It has a neurotoxic metabolite, normeperidine, which accumulates with repeated dosing and can produce anxiety, tremors, myoclonus and generalized seizures.
- **Maximize utilization of long-acting opiate analgesics**
  - Excessive use of short-acting opiate analgesics may indicate inadequate pain relief. Chronic use of short-acting opiates has been shown to increase the potential for abuse; therefore, they are best reserved for breakthrough pain. Long-acting opiates can provide sustained pain relief with less frequent dosing.
- **Identify coordination of care issues: patient is using multiple opiates from multiple prescribers**
  - Obtaining opiate analgesics from more than one physician may suggest inadequate pain management. To monitor and optimize a patient's opiate usage, opiates should be prescribed by only one physician or one pain management team whenever possible. Treatment from one physician encourages continuity of care and can improve pain management.

Issues to Consider When Treating Chronic Noncancer Pain [1-4]

SHORT-ACTING OPIATES

- For initial treatment of moderate to severe pain or for breakthrough pain while on a long-acting opiate agent
- Ceiling dose effects for acetaminophen- or ibuprofen-containing opiates
- Often associated with sedating or euphoric side effects
- Chronic use may increase risk of developing aberrant drug-related behavior in at-risk individuals

LONG-ACTING AND CONTROLLED-RELEASE OPIATES

- Considered the opiate products of choice for chronic pain, improved patient compliance and satisfaction
- Provide consistent levels over extended time periods and are less likely to produce tolerance
- May provide less reinforcement of aberrant drug-related behavior

GENERAL GOALS FOR CNCP MANAGEMENT

- Coordination of care by one physician and one pharmacy (a pain contract may be helpful - see next page)
- Multidisciplinary care may include: nurses, pharmacists, mental health care practitioners, physical therapists, etc.
- Education of patient and family regarding the safe and effective use of opiates
- Improved social and physical function
- Provision of regular follow-up and reassessment (consistent documentation is necessary)

Selected References (full reference list available upon request):

1. Chou R, Fanciullo G, Fine P, et al. Opioid treatment guidelines: clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. J Pain 2009;10(2):113-130.
2. Marcus DA. Treatment of nonmalignant chronic pain. Am Fam Physician 2000;61:1331-8.
3. Jackman RP, Purvis JM, Mallett BS. Chronic nonmalignant pain in primary care. Am Fam Physician 2008;78(10): 1155-64.
4. American Pain Foundation. Chronic pain and opioid treatment. Available at http://www.painfoundation.org/learn/publications/files/OpioidTherapy.pdf (accessed 10/20/10).

CONSENT TO TREAT CHRONIC NONCANCER PAIN WITH OPIATES
(Adapted from the AAPM consent form and the Federation of State Medical Board Guidelines)

Dr. _____ is prescribing an opiate medicine (sometimes called narcotic pain medicines) to me for the diagnosis of: _____.

I am aware of the possible side effects, which may include (but not limited to):

- Sleepiness or drowsiness
- Mental slowing and slowing of reaction time
- Slowing of breathing rate
- Dizziness
- Constipation
- Nausea and/or vomiting
- Itching or rash

I am responsible for my pain medication:

- I agree to take this medication as prescribed. I will not change my dose unless discussed and approved by my doctor.
  - ❑ Increasing the dose without guidance from my doctor increases the risk of side effects as listed above.
  - ❑ If I decrease or stop my medication, it can lead to withdrawal. Withdrawal symptoms may include yawning, watery eyes, runny nose, tremors, nervousness, difficulty sleeping, aching muscles, goose bumps, stomach cramping or diarrhea.
- This medication is for my use only.
- Except for emergencies, I will not ask any other doctor for opiate medicines. If I do, I will inform my doctor's office.
- I will not abuse my opiate medication or other drugs.
- Use of alcohol with opiate medications can cause excessive sleepiness, excessive slowing of breathing rate or even death.
- I agree to have random urine or blood sampling performed on me as requested by my doctor. These samples will be testing for prescribed or non-prescribed medications.

My prescriptions for opiate medications:

- Will be filled by the following pharmacy (s):

  _____ Phone Number _____
- Will be written during regular office hours, Monday through Friday. They will be picked up in person.
- Will not be called or mailed into the pharmacy.
- Will be written only for a one-month supply.
- Will not be rewritten if "I run out early" or "lose a prescription" or "spill my prescription". I am responsible for taking the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will call the police and obtain a police report. Replacement prescriptions will be written at the discretion of my doctor.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions answered to my satisfaction. By signing this form, I give my consent to treat my pain with opiate medications.

Patient Signature _____ Date _____

Printed Name_____

Witness_____Physician_____